

JAN 22 1941 875

Registration District No. 875

Primary Registration District No. 6162

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Permon
(b) City or town Mountain Grove
(c) Name of hospital or institution:
State Hosp # 3
(d) Length of stay: In hospital or institution 3 months
In this community Same
years, months or days 3

3. (a) PRINT FULL NAME Napoleon Nuckols
8. (b) If veteran, name war _____ 8. (c) Social Security No. None

4. Sex Male 6. Color or race White
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife May King Nuckols 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased DK DK DK
(Month) (Day) (Year)

8. AGE: Years 79 Months DK Days DK If less than one day hr. _____ min. _____

9. Birthplace DK (City, town, or county) (State or foreign country)

10. Usual occupation Labourer 9

11. Industry or business 9

MOTHER FATHER { 12. Name DK 9
13. Birthplace DK 9
(City, town, or county) (State or foreign country)

{ 14. Maiden name DK
15. Birthplace DK
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Fred
(b) Address Newsa

17. (a) Dura (b) Date thereof Dec 31-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Long St

18. (a) Signature of funeral director Russell Barber
(b) Address Mtn. Grove, Mo.

19. (a) Dec 30 1940 (b) Allen D. Stange
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Texas
(c) City or town Mountain Grove
(d) Street No. Local
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 30
year 1940 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from Sept 30
1940 to Dec 130 1940
that I last saw him alive on Dec 29 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Due to Generalized arteriosclerosis
Due to Senility
Other conditions 92C
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
795
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Wm. R. Remy (M. D. or other) _____
Address W. Remy Ma Date signed 12/30/40

RECEIVED

District Health Officer No. 71

District File Number 1-41-123

Date Filed 1-13-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Russell Barber

Licensed Embalmer No. 3848

P. O. Address 217 Grove St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.